STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

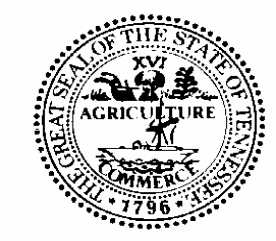
OF

VOLUNTEER STATE HEALTH PLAN, INC.
d\b\a BlueCare and
d\b\a TennCare Select

CHATTANOOGA, TENNESSEE

FOR THE PERIOD JANUARY 1, 2006
THROUGH JUNE 30, 2006

TABLE OF CONTENTS



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DATE: July 17, 2007

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Volunteer State Health Plan, Inc., Chattanooga, Tennessee, was completed December 8, 2006. The report of this examination is herein respectfully submitted.

I. FOREWORD

On October 13, 2006, the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) notified Volunteer State Health Plan, Inc., (VSHP) of its intention to perform a market conduct and limited scope financial statement examination. Fieldwork began on November 27, 2006, and ended on December 8, 2006.

This report includes the results of a market conduct examination "by test" of the claims processing system of VSHP. Further, this report reflects the results of a limited scope examination of financial statement account balances as reported by VSHP. This report also reflects the results of a compliance examination of VSHP's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of VSHP was conducted by TDCI under the authority of Section 3-6. of the Contractor Risk Agreement (CRA) between the State of Tennessee and VSHP, Section 2-15 of the Agreement for the Administration of TennCare Select between the State of Tennessee and VSHP (AATS), Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) §§ 56-32-215 and 56-32-232.

VSHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of VSHP. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statement as reported by VSHP on its National Association of Insurance Commissioners (NAIC) second quarter statement for the period ended June 30, 2006, and the Medical Services Monitoring Report filed by VSHP as of June 30, 2006.

The limited scope compliance examination focused on VSHP's provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with non-discrimination reporting requirements and the Insurance Holding Company Act.

Fieldwork was performed using records provided by VSHP before and during the onsite examination of records from November 27, 2006 through December 8, 2006.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that VSHP's TennCare operations were administered in accordance with the CRA, the AATS, and state statutes and regulations concerning HMO operations, thus reasonably assuring that VSHP's TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether VSHP met certain contractual obligations under the CRA and the AATS and whether VSHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq*. and Tenn. Code Ann. § 56-11-201 *et seq.*:

- Determine whether VSHP had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether VSHP properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether VSHP had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether VSHP had corrected deficiencies outlined in prior examinations of VSHP conducted by TDCI.

III. PROFILE

A. Administrative Organization

Volunteer State Health Plan II, Inc. (VSHP II), a wholly-owned subsidiary of Blue Cross Blue Shield of Tennessee, Inc. (BCBST), was chartered as a for-profit corporation in the State of Tennessee on July 1, 1996, for the purpose of providing managed health care services to individuals participating in the state's TennCare Program in all community service areas except the Knox County and East Tennessee community service areas. On November 8, 1996, by way of the Articles of Amendment to the Charter, VSHP II changed its name to Volunteer State Health Plan, Inc.

On January 1, 1998, VSHP merged with Volunteer State Health Plan-Eastern Tennessee, Inc., (VSHP-ET), a not-for-profit corporation also wholly owned by BCBST. VSHP-ET was a licensed HMO that participated in the TennCare Program in the Knox County and East Tennessee Community Service Areas. VSHP was the surviving corporation after the merger was completed. After the merger of VSHP and

VSHP-ET, VSHP provided coverage statewide to TennCare enrollees. As of the examination period ending June 30, 2006, BSCBST directly owned 1005 of VSHP's stock. See Subsequent Event (Section VI. E.) for change of ownership that occurred January 1, 2007.

The officers and board of directors for VSHP at June 30, 2006, were as follows:

Officers for VSHP

Vicky Brown Gregg, Chairman
Ronald Ellis Harr, President and CEO
Sonya Kay Nelson, Vice President, Medical Administration
Sylvia Ann Sherrill, Vice President, Medicare Advantage
Sheila Dean Clemons, Secretary
David Lee Deal, Treasurer and CFO
Harold Hoke Cantrell, Jr., Assistant Treasurer

Board of Directors or Trustees for VSHP

Ronald Ellis Harr
David Lee Deal
Charles Timothy Gary
Vicky Brown Gregg
Steven Lee Coulter, MD

B. Brief Overview

Effective November 4, 1996, TDCI granted VSHP II (later VSHP) a certificate of authority to operate as a TennCare HMO. Thereafter, VSHP began operating as a statewide MCO in the TennCare program. VSHP operated this line of business under the plan name BlueCare.

Effective July 1, 2001, VSHP's contract with the TennCare Bureau limited BlueCare enrollment to the Eastern Grand Region. Also effective July 1, 2001, VSHP entered into an administrative services agreement with the TennCare Bureau to administer a safety net plan called TennCare Select. Under this agreement, the state, and not VSHP, is at risk for the cost of medical services. TennCare Select provides services for children in state custody or at risk of being placed in state custody, children eligible to receive Social Security Income, children receiving services in an institution or under the state's Home and Community Based Service waiver, and TennCare enrollees residing out-of-state. Furthermore, TennCare Select has received additional enrollment from MCOs with terminated TennCare contracts. These enrollees remain in TennCare Select until the Bureau of TennCare determines if the remaining contracted TennCare MCOs are able to accept additional enrollees.

VSHP derives the majority of its revenue from payments from the state for providing medical benefits to TennCare enrollees. As of June 30, 2006, VSHP had 205,300 BlueCare members and approximately 396,900 TennCare Select members.

Subsequent to the examination period ending June 30, 2006, TennCare selected two health maintenance organizations through an RFP process to serve TennCare enrollees in the Middle Tennessee Grand Region effective April 1, 2007. TennCare Select continues to provide medical services on a state-wide basis for children in state custody or at risk of being placed in state custody, children eligible to receive Social Security Income, children receiving services in an institution or under the State's Home and Community Based Service waiver for enrollees in the Middle Tennessee Grand Region. As of April 1, 2007, total statewide enrollment for TennCare Select was approximately 100,600.

VSHP's BlueCare plan is currently authorized by TDCI and the TennCare Bureau to participate in the TennCare program in the Eastern Grand Region. VSHP's TennCare Select program operates statewide.

Effective July 1, 2002, the CRA with VSHP was amended for BlueCare to temporarily operate under a no-risk agreement. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. BlueCare agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During stabilization, VSHP receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to BlueCare. The TennCare Bureau reimburses VSHP for the cost of providing covered services to TennCare enrollees.

C. Claims Processing Not Performed by VSHP

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy
- Behavioral Health

During the period under examination, VSHP did not subcontract with vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by the TDCI for the period January 1, 2004, through December 31, 2004:

A. Financial Deficiencies

1. Administrative Expenses as reported on the Underwriting and Investment Schedule – Part 3, were not allocated in accordance with Statutory Accounting Principle Number 70.

This deficiency is repeated in this report.

B. Claims Processing Deficiencies

1. VSHP did not process claims promptly within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1), Section 2-18 of the CRA, and Section 2-9.7.b of the AATS for the month of October 2004.

This deficiency is not repeated in this report.

C. Compliance Deficiencies

1. The documentation maintained to support the data in the provider appeal log was not adequate for several appeals selected for testing.
2. The provider dispute log did not indicate the received date of the provider disputes.
3. For the three provider contracts tested, VSHP was unable to verify that all amendments to the contracts were executed in accordance with provisions outlined in the provider contracts themselves and in the CRA and the AATS. As a result, the examiners could not verify that the executed provider agreements reviewed correspond to the provider agreements templates approved by TDCI.

Deficiency number 3 is repeated as part of this report.

V. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The detail of testing as well as management comments to each finding can be found in Sections VI, VII, and VIII of this examination report.

A. Financial Deficiencies

1. Called and matured securities comprising the restricted deposit were not promptly replaced or substituted during the examination period. (Section VI.A.2)

2. Administrative Expenses as reported on the Underwriting and Investment Schedule – Part 3, were not allocated in accordance with Statutory Accounting Principle Number 70. (Section VI.A.4)

3. VSHP incorrectly classified $543,734.86 due to the State for premium taxes as General Expenses Due and Accrued. (Section VI.A.5.)

4. VSHP overstated its investment income receivable and investment revenue by $20,687. Because VSHP transfers its investment income to the parent, administrative expense and the payable to the parent were similarly overstated.(Section VI.A.6.)

5. In preparing the Medical Fund Target Report and the Medical Services Monitoring Report, VSHP did not report recoveries of claims payments correctly. These recoveries should be reported as reductions to medical expense in the month the claim was paid rather than in the month claims payments were recovered. (Section VI.C.)

B. Claims Processing Deficiencies

1. VSHP did not maintain documentation of the results for each attribute tested in Claims Payment Accuracy Reports. (Section VII. C. 2.)

C. Compliance Deficiencies

1. VSHP did not maintain evidence that providers received notification of amendments to their provider agreements per section 2.18.cc. of the CRA and the AATS. (Section VIII.C.)

2. VSHP did not obtain prior approval from the TennCare Bureau or TDCI before executing an agreement with a hospital for provider credentialing services in violation of Sections 2-9.f and 2-17 of the CRA and Tenn. Code Ann. § 56-32-203(c)(1). (Section VIII.E.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, VSHP is required to file annual and quarterly NAIC financial statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed in these reports to determine if VSHP meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because “admitted” assets must be easily convertible to cash, if necessary, to pay outstanding claims. “Non-admitted” assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At June 30, 2006, VSHP reported $42,511,841 in admitted assets, $11,944,878 in liabilities and $30,566,963 in capital and surplus on its NAIC annual statement. VSHP reported net income of $146,187 on its statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires VSHP to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

2005 Statutory Net Worth Calculation

VSHP's premium revenue totaled $1,601,689,265 for calendar year 2005; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), VSHP's statutory net worth requirement for the calendar year 2006 is $27,775,339. VSHP reported total capital and surplus of $30,566,963 as of June 30, 2006, which is $2,791,624 in excess of the minimum statutory net worth requirement.

Premium Revenue for the Examination Period

The following is a summary of VSHP's premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2) for the period January 1, 2006 through June 30, 2006:

BLUECARE

Administrative fee payments from TennCare for the period January 1 through June 30, 2006	$ 14,782,316
Reimbursement for medical payments from TennCare for the period January 1 through June 30, 2006	318,610,303
Reimbursement for premium tax payments from TennCare for the period January 1 through June 30, 2006	6,667,852

TENNCARE SELECT

Administrative fee payments from TennCare for the period January 1 through June 30, 2006	$ 32,332,752
Reimbursement for medical payments from TennCare for the period January 1 through June 30, 2006	455,652,021
Reimbursement for premium tax payments from TennCare for the period January 1 through June 30, 2006	9,759,695
Total premium revenue January 1 through June 30, 2006	$837,804,939

2. Restricted Deposit

Beginning July 1, 2005, an amendment to the CRA required MCOs to have on restricted deposit an amount equal to the calculated statutory net worth. Based upon premium revenues for calendar year 2005 totaling $1,601,689,265, VSHP's statutory deposit requirement at June 30, 2006, was $27,775,339.

At June 30, 2006, VSHP had on file an amended depository agreement of $27,775,339. The depository agreement is an executed agreement between the Commissioner of the Department of Commerce and Insurance, VSHP and the Federal Reserve Bank. The bank shall be accountable to the Commissioner and the HMO for the safekeeping of the securities held by it under the depository agreements.

A comparison of the pledged securities as of June 30, 2006 held by TDCI revealed that a security with a par value $1,000,000 was called in November 2005, and another security with a par value of $1,200,000 matured on June 15, 2006. It was not until August 2006 that VSHP pledged two new securities with a total par value of $2,200,000 to replace the called and matured securities.

VSHP should maintain the required restricted deposit by replacing called securities pursuant to TDCI's established procedures. VSHP should closely monitor maturity dates of securities comprising the restricted deposit and react to securities which are called or matured. VSHP can withdraw or substitute securities comprising the restricted deposit but such withdrawal of securities may be made only upon proper written instructions signed by an authorized official of VSHP and the Commissioner as stated in VSHP's Depository Agreement.

Management's Comments

Management concurs and has established controls to replace called and matured securities in a more timely manner.

3. Claims Payable

As of June 30, 2006, VSHP reported no claims unpaid on the NAIC annual statement. Claims unpaid represents an estimate of unpaid claims or incurred but not reported (IBNR) for only the "at risk" period ending June 30, 2002. Review of the triangle lag payment report after June 30, 2006, for dates of service before July 1, 2002, determined that the reported claims payable is reasonable.

4. Management Agreement and Administrative Expense Allocations

BCBST provides administrative services to VSHP's BlueCare and TennCare Select lines of business. The fee VSHP paid to BCBST for administrative services is based on a management agreement approved by TDCI.

During the examination period January 1, 2006, through June 30, 2006, the BlueCare and the TennCare Select lines of business were paid monthly fixed administrative fees by the TennCare Bureau in exchange for administrative services by VSHP per Section 2.9.e.1 of the CRA and Section 4-1.1.d of the AATS. This fixed administrative fee along with the net investment income earned is paid by VSHP to BCBST for administrative services. It should be noted that interest earned on ASO funds is the property of the state and is not transferred to BCBST.

The NAIC instructions require that an HMO that has paid management fees to an affiliated entity "shall allocate these costs to the appropriate expense classification item (salaries, rent, postage, etc.) as if these costs had been borne directly by the company. . . The reporting entity may estimate these expense allocations based on a formula or other reasonable basis."

The NAIC's Statement of Statutory Accounting Principles No. 70 requires that these expenses be further allocated to three general categories – claims adjustment expense, general administrative expense, and investment expense. Allocation to these categories "should be based on a method that yields the most accurate results." Specific identification of an expense with an activity that is represented by one of the categories will generally be the most accurate method. Where specific identification is not feasible allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analysis."

The Underwriting and Investment Exhibit – Part 3 is not required for quarterly

NAIC filings, but TDCI requested this form at June 30, 2006, to determine if VSHP had corrected the previous finding regarding the allocation of the management fee paid to BCBST. TDCI noted in the previous examination that VSHP used percentages derived from the administrative expenses incurred by the parent, BCBST, and reported by line item on the parent's annual statement to allocate the management fee to expense classifications on the Underwriting and Investment Exhibit – Part 3. VSHP continued to utilize this method for the examination period.

VSHP should review its methodology for apportioning management fees to NAIC administrative expense classifications and categories. VSHP should allocate management fees to expense classifications as if these costs had been borne by VSHP itself and then allocate expenses to administrative categories by specific identification. If specific identification is not possible, then allocation based on percentages is acceptable. VSHP should maintain documentation to prove that the allocation is reasonable and that it yields the most accurate results.

Changes to the current allocation methodology will not affect reported net income or net worth, but the improved methodology will provide a more accurate representation of VSHP's administrative expenses.

Management Comments

Volunteer State Health Plan (VSHP) as a reporting entity, pays BlueCross BlueShield of Tennessee (BCBST) for the management and administration of VSHP business operations. The cost of operations paid to BCBST is reported on the 12/31/2005 "Underwriting and Investment Exhibit Part 3 – Analysis of Expenses" in the appropriate expense classification as if these costs had been borne directly by VSHP. This basis is described in the NAIC annual statement instructions.

BCBST's "Underwriting and Investment Exhibit Part 3 – Analysis of Expenses" serves as the basis for allocating the VSHP expense payments to the appropriate expense classification. We believe this treatment is compliant with the NAIC's Statement of Statutory Accounting Principles No. 70 and is consistent with how we have handled in the past. Because costs directly borne by dedicated operational areas were such a small percentage of VSHP's total costs, BCBST's expense categories were the most accurate basis for reporting VSHP expenses in the period under audit. However, we plan to make changes to our cost structure that allows more direct allocation of costs borne by BCBST on behalf of VSHP, and plan to move current BCBST employees working solely for the benefit of VSHP from BCBST to BSHP. The move of employees is planned to take effect on January 1, 2008 and will be accompanied by a revised Administrative Services Agreement (ASA) between BCBST and VSHP. As with prior changes to the ASA between BCBST and VSHP, both the Department of Commerce and Insurance and the TennCare Bureau will be given an opportunity to review and comment prior to implementation. We plan to reflect these

proposed changes in the calendar year 2008 reporting period.

5. General Expenses Due or Accrued

VSHP reported $543,734.86 in premium tax payable to the State as a component of General Expenses Due or Accrued. This amount represents premium tax payable for payments that pass through VSHP for Meharry dental services, Critical Access payments and Essential Provider Payments. The NAIC Quarterly Statement Instructions for 2006 state that this line item should only include amounts due to trade vendors.

VSHP should reclassify this item as a write-in and include only trade accounts payable in the line item General Expenses Due or Accrued. This reclassification will not affect reported net income.

Management Comments

Management does not concur. Volunteer State Health Plan, Inc. (VSHP) reports premium taxes payable as 'General Expenses Due and Accrued' on statutory filings. We understand TDCI's comment that premium tax is not appropriately classified as "General Expenses Due and Accrued' (amounts due to creditors for the acquisition of goods and services on a credit bases). However, this classification is needed so that supporting exhibits within the statutory filing will tie to the balance sheet.

The Underwriting and Investment Exhibit, Part 3 lists all expenses paid (including premium taxes – line 23.2). This exhibit picks up the change in General Expenses Due and Accrued. Therefore, the General Expenses Due and Accrued must include premium taxes payable for the exhibit to calculate paid expenses correctly.

If premium taxes are included in 'General Administrative' expenses, but not in the 'General Expenses Due and Accrued,' the paid calculation will be misstated on the Underwriting and Investment Exhibit, Part 3.

TDCI's Rebuttal

TDCI agrees that premium taxes should be reported on line 23.2 of the Underwriting and Investment Exhibit, Part 3. Also, the NAIC Annual Statement Instructions Health states that General Expenses Due or Accrued reported on the balance sheet should agree with the Underwriting and Investment Exhibit, Part 3, Column 3 and Column 4, Line 27. However, the NAIC Annual Statement Instructions Health is specific for items to be included in General Expenses Due or Accrued. Other line items on the liabilities page of the NAIC blank may also affect general expenses paid during the year. The instructions specifically require the separate listing of each category of liabilities for which there is no preprinted line. The proper disclosure of the liabilities on the balance sheet is of

greater relevance than the cross referencing error resulting on the sub schedule, Underwriting and Investment Exhibit, Part 3 or the determination of General Expenses paid on the sub schedule.

6. Investment Income Due and Accrued

At June 30, 2006, VSHP overstated interest receivable and interest income by $20,686.63. VSHP explained that there is no effect on net income because interest from investments is transferred to BCBST. Therefore, the administrative expense and payable are overstated by the same amount.

Management Comments

Management concurs and understands the finding while noting that there is no impact on net income or reserves.

B. Administrative Services Only (ASO)

As previously mentioned, the CRA and the AATS between VSHP and the State of Tennessee does not currently hold VSHP financially responsible for medical claims. This type of arrangement is considered "administrative services only" as defined by the NAIC guidelines. Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO plan. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected in the balance sheet.

Although VSHP is under an ASO arrangement as defined by NAIC guidelines, the CRA and AATS require a deviation from those guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if VSHP were still operating at risk. As stated in Section 2-10.h. of the CRA and the AATS, VSHP is to provide "an income statement addressing the TennCare operations." TennCare HMOs provide this information on the Report 2A submitted as a supplement to the NAIC financial statements. No deficiencies were noted in the preparation of VSHP's Report 2A for the period ending June 30, 2006.

C. Medical Fund Target and Medical Services Monitoring

Effective July 1, 2002, the CRA and the AATS required VSHP to submit for TenCare Select a Medical Fund Target (MFT) report monthly. The MFT accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for IBNR claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT report. VSHP submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be

reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for expenses incurred but not reported have been reviewed for reasonableness.

Effective July 1, 2005, the CRA requires VSHP to submit for BlueCare a Medical Services Monitoring report (MSM) on a monthly basis. The MSM accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MSM. VSHP submitted monthly MSM reports which included actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures were supported by a letter from an actuary which indicated that the MSM estimates for IBNR expenses were reviewed for accuracy.

During TDCI's review of the MFT and the MSM, examiners noted that VSHP incorrectly reported recoveries of claims payments. VSHP reported the recoveries as reductions to medical expenses in the month VSHP received the recoveries. The reports are designed to account for medical expenditures based on service month. VSHP should apply the recoveries to the month the related claim was processed.

Management Comments

Management concurs. VSHP did not adjust subrogation through the claims system until January of 2005. If VSHP reports by incurred date (beginning with paid dates of January 2005), the reports will be inconsistent for subrogation for pre/post January 2005. Pre-January 2005 collections will be reflected by collected date and post-January 2005 collections will be reported by incurred date.

VSHP will begin reporting post-January 2005 collections by an incurred basis as soon as programming changes can be implemented to include recoveries in the paid claims tables.

D. Umbrella Agreement

In addition to the CRA and AATS agreements, VSHP also contracts with the State of Tennessee through a TennCare Umbrella Participation Agreement. The Umbrella Agreement includes language defining enrollment limits, special payments, and minimum financial guarantees. Section 2.F. states:

> In the event that the total of administrative fee payments paid to the Contractor according to the terms and conditions of the CRA and the terms and conditions of the Select Agreement are less than five million dollars ($5,000,000.00) per month for the period January 1, 2006 through December 31, 2006, TennCare shall make payment equivalent to the difference between the total of administrative fee payments made pursuant to the CRA and administrative fee payments made pursuant to the Select Agreement and five million dollars ($5,000,000.00) per month

> for the period January 1, 2006 through December 31, 2006, within 120 calendar days of December 31, 2006. Administrative fee payments for retroactive eligibility periods shall be counted in the month to which the payment applies.

For the examination period, January 1 through June 30, 2006, monthly administrative fee payments were in compliance with contract terms.

E. Subsequent Event

As previously noted in this report, BCBST directly owned 100% of VSHP as of the end of the examination period on June 30, 2006. BCBST also owns 100% of Southern Diversified Business Services, Inc. (SDBS). Effective January 1, 2007, BCBST transferred 100% of the stock of VSHP to SDBS. The transaction did not affect the financial results of VSHP and BCBST remains the ultimate controlling entity of VSHP.

The management agreement between VSHP and BCBST remains in effect after the stock transfer. Employees of BCBST are still responsible for performing the administrative functions of VSHP. VSHP does not purchase services from SDBS.

Although VSHP should have informed TDCI of the transfer prior to its execution on January 1, 2007, this transaction does not represent a change in control as defined by Tenn. Code Ann. § 56-11-201(b)(3).

F. Schedule of Examination Adjustments to Capital and Surplus

There were no adjustments to capital and surplus as a result of the examination.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1) and Section 2-18. of the CRA and 2-9.12.1 of the AATS. The statute mandates the following prompt payment requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.

> (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
>
> (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-226(b)(1) by testing in three-month increments data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. If a TennCare MCO fails to meet the prompt pay standards in any of the three months tested, TDCI, at a minimum, requires claims data submissions on a monthly basis for the next three months to ensure the MCO remains compliant.

The prompt pay testing results for the examination period and subsequent testing by TDCI through January 2007 are as follows:

Medical Results – BlueCare

	Clean Claims Within 30 Days	All Claims Within 60 Days	Compliance
T.C.A. Requirement	*90%*	*99.5%*	
January 2006	99%	100%	Yes
February 2006	99%	100%	Yes
March 2006	99%	100%	Yes
April 2006	99%	100%	Yes
May 2006	100%	100%	Yes
June 2006	100%	100%	Yes
July 2006	99%	99.9%	Yes
August 2006	99%	100%	Yes
September 2006	97%	99.9%	Yes
October 2006	99%	100%	Yes
November 2006	98%	99.9%	Yes
December 2006	96%	99.9%	Yes
January 2007	93%	99.9%	Yes

Medical Results – TennCare Select

	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	*90%*	*100%*	
January 2006	99%	100%	Yes
February 2006	100%	100%	Yes
March 2006	100%	100%	Yes
April 2006	99%	99.9%	Yes
May 2006	100%	100%	Yes
June 2006	100%	100%	Yes
July 2006	100%	100%	Yes
August 2006	100%	100%	Yes
September 2006	100%	100%	Yes
October 2006	100%	100%	Yes
November 2006	95%	99.9%	Yes
December 2006	95%	100%	Yes
January 2007	93%	99.9%	Yes

VSHP processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) claims processing requirements for the examination period and subsequent testing through January 2007.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of testing performed on VSHP's claims processing system.

The following items were reviewed to determine the risk that VSHP had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints or independent reviews on file with TDCI related to accurate claims processing
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims processing accuracy reports
- Review of internal controls.

C. Claims Payment Accuracy Report

Section 2-9. of the CRA and Section 2-9.12.2 requires that 97% of claims are paid accurately upon initial submission. VSHP is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

VSHP reported the following results for the examination period:

BlueCare

	Results Reported	Compliance
First Quarter 2006	99.6%	Yes
Second Quarter 2006	99.4%	Yes

TennCare Select

	Results Reported	Compliance
First Quarter 2006	99.7%	Yes
Second Quarter 2006	99.5%	Yes

During the examination period, VSHP was in compliance with Section 2-9 of the CRA.

1. Procedures to Review the Claims Payment Accuracy Reporting

The review of the claims processing accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. This review included verification that the number of claims selected by VSHP constituted an adequate sample to represent the population. These interviews were followed by a review of the supporting documentation used to prepare the second quarter 2006 claims payment accuracy report. In addition TDCI selected for review ten claims reported as errors from each line of business from VSHP's second quarter 2006 report. The selected claims were reviewed to determine that the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation were traced directly to the actual report filed with TennCare.

2. Results of Review of the Claims Payment Accuracy Reporting

TDCI found no problems with VSHP's reported percentage in the Claims Payment Accuracy Report. During the review of procedures, however, TDCI noted that VSHP did not maintain a listing of the required testing elements specified in Section 2.9.m.2. of the CRA and Section 2.9.12.2. of the AATS. This list should be maintained for audit and verification purposes.

Management Comments

Management concurs and implemented an electronic checklist that includes the required testing elements effective January 10, 2007. The checklist is now completed for each audited claim and maintained as part of our electronic audit record.

D. Claims Selected For Testing From Prompt Pay Data Files

TDCI selected thirty BlueCare claims and thirty TennCare Select claims from the June 2006 prompt pay data files submitted to TDCI. For each claim processed, the data files included the date received, date paid, the amount paid, and if applicable, an explanation for denial of payment.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by VSHP.

To ensure the second quarter 2006 data files included all claims processed in those months, the total amount paid per the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in VSHP's claims processing system. Attachment XII Exhibit G of the CRA and AATS requires minimum data elements to be recorded from medical claims and submitted to TennCare as encounter data. Original hard copy claims were requested for the sixty claims tested. If the claim was submitted electronically, the original electronic submission file associated with the claim was requested.

The data elements recorded on the claims were compared to the data elements entered into VSHP's claims processing system. No discrepancies were noted between the information submitted on the claims and the data recorded in VSHP's system.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. For the sixty claims selected, no discrepancies were noted.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly. There were no discrepancies noted in the sixty claims tested.

H. Copayment Testing

The purpose of testing copayment is to determine if enrollees are subject to out-of-pocket payments for certain procedures, if out-of-pocket payments are within liability limitations, and if out-of-pocket payments are accurately calculated. Because the sixty claims selected for testing did not include any claims with copays, examiners expanded testing and selected three BlueCare claims and three TennCare Select claims with a copay calculated. No discrepancies were noted in the review of these claims.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

The examiners requested remittance advices for ten of the sixty claims selected for testing to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the related information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to: (1) verify the actual payment of claims by VSHP; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested cancelled checks for ten claims which were also selected for remittance advice testing. VSHP provided the cancelled checks. The check amounts agreed with the amounts paid per the remittance advice and no pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended and Unpaid Claims Testing

The purpose of analyzing pended claims is to determine if a significant number of claims are unprocessed and as a result a material liability exists for the unprocessed claims.

The pended and unpaid data file submitted to TDCI as of January 31, 2006, April 30, 2006, and July 31, 2006, indicates that no claims exceeded sixty days at January 31, 2006, and April 30, 2006. Only three TennCare Select claims exceeded sixty days at July 31, 2006. No material unrecorded liability exists for claims exceeding sixty days.

L. Electronic Claims Capability

Section 2-9.m.1. of the CRA states, “The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment . . .” The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) requires that all health plans are able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with

the standards defined for the transactions listed can result in the assessment of substantial penalties.

VSHP has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes.

M. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures by VSHP ensure that all claims received from providers are either returned to the provider where appropriate or processed by the claims processing system. The review of mailroom and claims inventory controls included a walk through with mailroom and claims processing personnel. Based on the review, controls in the mailroom and claims inventory controls were adequate.

Ten claims were judgmentally selected from a batch of incoming mail to determine if the claims were entered into the claims processing system with correct received date. All ten claims were entered into the claims processing system with the correct received date.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

Provider complaints were tested to determine if VSHP properly responded to all provider complaints in a timely manner. Ten provider complaints were selected from a list provided by VSHP. Tenn. Code Ann. § 56-32-226 states:

> The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request with an estimated time frame in which the health maintenance organization will complete its investigation and provide a complete response to the provider. If the health maintenance organization determines that it needs longer than thirty 30 calendar days to completely respond to the provider, the health maintenance organization's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the health maintenance organization.

TDCI selected ten provider complaints for review. No discrepancies were noted.

B. Provider Administration Manual

The HMO's provider manual informs healthcare providers of applicable policies and

procedures to be used to carry out their responsibilities as set forth in their provider agreements. The provider manual outlines guidelines to be followed by providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. VSHP submits updates to its provider manual to TDCI for approval on a quarterly basis. The Compliance Section of the TDCI TennCare Division approved the latest quarterly update on December 7, 2006.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include, but are not limited to, standards of care, assurance of TennCare enrollees' rights, compliance with all federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the CRA and the AATS between VSHP and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of the CRA requires that all provider agreements executed by VSHP shall meet the current requirements listed in Section 2-18 of the CRA and the AATS.

Section 2-18.cc of the CRA and the AATS requires the following language in all provider agreements to insure that MCOs do not effect changes to contracts unilaterally:

> Specific procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments to be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc).

VSHP's provider manual is incorporated by the reference into the provider agreements. From time to time, VSHP amends provider agreements via changes to the provider manual. Therefore, VSHP must comply with the notification requirements Section 2-18.cc of CRA and AATS above. VSHP should maintain proof of receipt of notification for changes to the provider manual which effectively

amend VSHP's provider agreements.

Management Comments

Management concurs. Effective with the First Quarter 2007 mailing of the BlueSource CD, which contains the BlueCare Provider Administration Manual, these updates are disseminated via certified mail.

D. Provider Payments

Examiners tested capitation payments to providers during the examination period to determine if VSHP had complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per contract requirements.

E. Subcontracts

HMOs are required to file a notice and obtain the Commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). VSHP subcontracted with a hospital to provide credentialing services. The subcontract was executed without prior approval by TDCI or the TennCare Bureau in violation of Sections 2.9 and 2-17(c) of the CRA and Section 17(c) of the AATS.

Management Comments

Management concurs. The Agreement in question has been submitted to the TennCare Division of the Tennessee Department of Commerce and Insurance for review, and approved by the Department on March 19, 2007. The Agreement was submitted to the Bureau of TennCare for review and approval on February 21, 2007, and we are currently holding for their response.

F. Non-discrimination

Section 2-24 of the CRA and the AATS requires VSHP to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various VSHP staff and a review of policies and related supporting documentation, VSHP was in compliance with the reporting requirements of these sections of the CRA and the AATS.

G. Stabilization

VSHP has operated the TennCare Select line of business as an ASO product since its inception in July 2001. Effective July 1, 2002, VSHP's CRA was amended so that BlueCare would operate as an ASO as well. While the provisions tested below

have always been a requirement for TennCare Select, they only are effective for BlueCare transactions with dates of service after July 1, 2002.

Section 3-10.h.2(a) of the CRA requires VSHP to comply with the following policies and procedures as they relate to the BlueCare line of business:

> The CONTRACTOR shall reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002 for covered services as defined in Section 3-10h.2(j), unless otherwise directed by TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider.

Section 5-2.1. of the AATS requires VSHP to comply with the following policies and procedures as they relate to the TennCare Select line of business:

> Providers shall be paid according to BlueCare policies and procedures and reimbursement rates in effect as of March 1, 2001, unless otherwise directed by TennCare…

VSHP's management confirmed compliance with all stabilization requirements. During testing of financial, claims processing, and provider contracts, TDCI noted no instances of non-compliance with these policies and procedures.

H. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the company. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

VSHP's Internal Audit Committee meets quarterly to discuss internal audit issues and plan focused reviews with the help of senior management. Internal audit staff also prepares the Claims Payment Accuracy Report. Internal audit staff report to the Audit Committee and the Audit Committee reports to the Board of Directors.

I. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…." VSHP has

complied with this statute.

J. Behavioral Health Organization (BHO) Coordination

VSHP was in compliance with Section 2-3.c.2. of the BlueCare CRA and Section 2-3.4. of the AATS effective July 1, 2002, whereby claims for covered services with specified primary behavioral diagnosis codes are submitted directly to VSHP for timely processing and payment.

VSHP is required to refer unresolved disputes between the HMO and BHO to the State for a decision on responsibility after providing medically necessary services. VSHP indicated that it did not have any ongoing disputes with the BHO.

K. Contractual Requirements for ASO Arrangements

As previously mentioned, effective July 1, 2002, VSHP's CRA was amended so that VSHP would operate as an ASO. As a result, the provisions tested below are a requirement for transactions with dates of service after July 1, 2002.

1. Medical Management Policies

Section 2-2.r. of the CRA requires the BlueCare line of business to comply with the following:

> Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as they existed on April 16, 2002, unless otherwise directed or approved by TennCare, and to submit copies of all medical management policies and procedures in place as of April 16, 2002 to the State for the purpose of documenting medical management policies and procedures before final execution of this Amendment.

VSHP's management confirmed compliance with the requirements described above. During testing of claims processing and provider contracts, no deviations to the requirement were noted.

2. Provider Payments

Section 3.10.h.2(b) of the CRA with BlueCare and Section 5-3.a of the AATS states that VSHP "shall release payments to providers within 24 hours of receipt of funds from the State." VSHP was in compliance with this requirement.

3. 1099 Preparation

Section 3-10.h.2(c) of the CRA and Section 5-3.b of the AATS state that VSHP "shall prepare and submit 1099 Internal Revenue Service reports for all providers to whom payment is made." Based on TDCI's review, VSHP has

complied with this requirement.

4. Interest Earned on State Funds

Section 3-10.h.2.(d) of the CRA and Section 5-3.c of the AATS state that interest generated by funds on deposit for provider payments related to the no-risk agreement period shall be the property of the State. TDCI traced amounts reported as interest received per bank statements to invoices submitted to the TennCare Bureau. TDCI determined that VSHP had remitted to the State interest earned on deposits for provider payments related to the no-risk agreement.

5. Recovery Amounts/Third Party Liability

Section 3-10.h.2.(f) and (g) of the CRA and Section 2.9.9. of the AATS require third party liability recoveries and subrogation amounts related to the no-risk agreement period be reduced from medical reimbursement requests of the TennCare Bureau. As third party liability and subrogation amounts are recovered, VSHP should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered. VSHP was in compliance with this requirement.

6. Pharmacy Rebates

Section 3-10.h.2.(e) of the CRA and Section 5-3.d of the AATS state that pharmacy rebates collected by VSHP shall be the property of the State. The pharmacy program was carved out of the HMO's responsibility in July 2003. VSHP was in compliance with this requirement.

L. Conflict of Interest

Section 4-7 of the CRA and Section 6-7 of the AATS warrant that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to VSHP in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Conflict of interest requirements of the CRA were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with the provisions required by the CRA shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total amount of

compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for including the substance of CRA conflict of interest clauses in all subcontracts, provider agreements, and any and all agreements that result from the CRA.

VSHP demonstrated the following efforts to ensure compliance with the conflict of interest clause of the CRA:

- The administrative service agreements between BCBST and VSHP for BlueCare and TennCare Select include the same conflict of interest language as the Contractor Risk Agreement.

- Provider Agreements contain the conflict of interest language of the Contractor Risk Agreement.

- BCBST employees complete conflict of interest questionnaire/disclosure statements.

- The organizational structure of BCBST includes a Chief Compliance Officer who reports directly to the Board of Directors and the Board Audit Committee.

- BCBST has an internal audit department which monitors day-to-day compliance issues as well as the performance of focused audits of Contractor Risk Agreement requirements.

- Standards for ethical guidelines have been formalized in a Code of Business Conduct for employees.

- A written compliance program has been developed to provide a mechanism to enforce the Code of Business Conduct. The compliance program includes, but is not limited to, the duties of the Chief Compliance Officer, auditing processes, and reporting violations.

- A Medicaid Compliance Unit exists within Internal Audit.

- The Medicaid Compliance Subcommittee, which meets at least six times per year, oversees compliance requirements resulting from all obligations under the CRA, AATS and all applicable federal and State laws, rules and regulations.

TDCI noted no instances of non-compliance with conflict of interest requirements during the examination test work.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of VSHP.